



Phone: 1-877-537-0722
FAX TO: 1-877-537-0720

Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

Brand-Name Multi-Source Drug
PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Medicaid #: _____

DOB: _____ City: _____
Month Day 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____ NPI#: _____

Provider #: _____ City: _____ State: _____

Phone: _____ Fax: _____

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Physician's Signature

Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider#: _____

City: _____ State: _____ Phone#: _____

Fax#: _____

DRUG/CLINICAL INFORMATION

Drug Name & Strength: _____ Quantity/Month: _____

Daily dose: _____ NDC#: _____

Diagnosis: _____

DOCUMENTATION OF TRIAL OF GENERIC PRODUCT

Generic Product: _____ Manufacturer: _____

Length of therapy _____

Observed adverse reaction or allergic reaction:

Documentation Included: Y___ N___

MedWatch Form Attached: Y___ N___

*MedWatch Form can be found at <http://www.fda.gov/medwatch/safety/3500.pdf>

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